

conducted in a primary care setting with patients newly prescribed co-amoxicillin for 3 up to 14 days. Community pharmacies are randomized to intervention or control group, they recruit patients and provide the app-based service. All participants use the TOM medication management app to track antibiotic intakes, keep a written symptom diary and evaluate their well-being on a 5-point smiley scale. In addition, the intervention group receives medication intake reminders and two types of text messages (educational and motivational) delivered via smartphone. At the end of therapy, adherence counseling is delivered by phone to all participants by the study team to discuss the recorded data (adherence, symptoms, well-being). An online survey is conducted to assess patient satisfaction with the service including the app. Based on the literature, the sample size was calculated with an anticipated 22% improvement in taking adherence, resulting in 58 patients per group (116 patients in total). The primary outcomes are adherence rates, including taking, dosing, and timing adherence. Secondary outcomes include persistence rates, dose-to-dose intervals, time to symptom resolution, time to well-being, the number and severity of symptoms categorized as adverse events, and overall satisfaction of patients and providers with the service. For analysis, both groups will be compared across all primary and secondary outcomes. The study has been approved by the local ethic committee and will be completed by December 2024.

Findings: Currently, 56 pharmacies agreed to participate and have recruited a total of 33 patients with an equal distribution between both study arms (Intervention: 16; Control: 17). Final study results will be presented at the conference.

Conclusion: n.a.

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Co-creation approach to adapting and implementing an interprofessional service targeting initiation adherence in Switzerland: myCare Start –Implementation Science project

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Background: The New Medicine Service (NMS), developed in the UK, was effective in improving medication adherence among patients initiating long-term medications. However, international scale up of this complex intervention has highlighted the need for meaningful intervention adaptation to address contextual differences and implementation barriers in new healthcare settings.

Purpose: Guided by the O' Cathain et al. (2019) Framework for intervention development and the ADAPT Guidance, the myCare Start –Implementation project (myCare Start-I) utilised a co-creation approach supplemented by contextual information, known theory and empirical evidence to adapt the NMS, developing a contextually fitting myCare Start service model for use within the ambulatory primary care medicine and community pharmacy setting in Switzerland.

Method: The co-creation process involved an exploratory qualitative approach, including repeated semi-structured focus groups with stakeholders (patients, physicians, and pharmacists) and consensus-based workshops with investigators to iteratively refine the intervention. An initial context analysis identified 63 contextual factors impacting intervention design or implementation of myCare Start in Switzerland. A panel of interprofessional investigators including primary care physicians and end-user representative (n=15) prioritised these factors,

assessing both the importance of addressing each factor and the confidence that it could be addressed in the Swiss context. The resulting priority areas formed the focus of repeated semi-structured stakeholder focus groups to discuss solutions and possible service adaptations. This iterative process culminated in 12 proposed adaptations of the original NMS intervention which were presented to the investigative team and assessed based on acceptability to Swiss context.

Findings: A total of 12 stakeholder focus groups (n=50 stakeholders) and two investigator consensus workshops led to a final list of seven selected intervention adaptations. Adaptations were mapped in accordance with the Framework for Reporting Adaptations and Modifications Expanded (FRAME). Adaptations occurred at both individual (e.g., flexible delivery modes, extended follow-up timeline, pharmaceutical device demonstration options, inclusion of support persons) and organizational levels (e.g., physician referrals to myCare Start, standardized pharmacist feedback to physicians and greater guidance for interventions to assist patients).

Conclusion: The co-creation process, as part of a multi-strategy intervention adaptation process successfully produced a contextually appropriate myCare Start model tailored to the needs of Swiss stakeholders. These adaptations are anticipated to enhance fit for the context, recipient and provider alignment, service feasibility, engagement and cultural relevance, that hopefully, will translate to improved intervention and implementation outcomes when the service is evaluated in a Type II hybrid effectiveness-implementation trial in 2025.

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Attitudes of Patients with Solid Tumors Towards Deprescribing Non-Cancer Medicines and Proton Pump Inhibitors

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Background: Proton pump inhibitors (PPIs) may reduce the effectiveness of systemic cancer treatments by altering the gut microbiome, emphasizing the importance of deprescribing inappropriate non-cancer medicines, including PPIs, to potentially improve survival outcomes.

Purpose: To assess the attitudes of patients with solid tumors towards deprescribing non-cancer medicines and PPIs.

Method: A cross-sectional study used the Slovenian version of the revised Patients' Attitudes Towards Deprescribing (rPATD) questionnaire, adapted for PPI use with additional questions about pharmacists' roles. The rPATD, using a Likert scale from 1 to 5, was completed by patients using PPIs before oncology consultations or during systemic cancer treatment in a hospital. The study evaluated the proportion of patients with solid tumors willing to stop non-cancer medicines and PPIs based on doctors' or pharmacists' advice and identified influencing factors.

Findings: Among 128 patients with cancer prescribed PPIs, 75 (58.6%) were female, with a median age of 66 years (IQR 16). Most had upper gastrointestinal (38; 29.7%), gynecological (29; 22.7%), thoracic (27; 21.1%), or lower gastrointestinal cancers (17; 13.3%). Patients reported taking a median of 3 non-cancer medicines (IQR 3).

The rPATD factor scores indicated a perceived medication burden (median 2.8, IQR 1.0), belief in medication appropriateness (median 3.4, IQR 1.0), concerns about stopping medicines (median 2.8, IQR 0.8), and high involvement in medication management (median 4.3, IQR 0.8).

A high willingness to deprescribe non-cancer medicines based on a doctor's advice was observed (89.9%), while willingness to deprescribe PPIs was lower (79.9%). Logistic regression indicated that older age (OR 1.05, CI 1.00–1.10; p 0.036), greater involvement in medication management (OR 3.13, CI 1.31–7.49; p 0.010), and fewer concerns about stopping PPIs (OR 0.36, CI 0.14–0.93; p 0.036) were associated with increased willingness to deprescribe PPIs on a doctor's advice.

Fewer patients were willing to deprescribe non-cancer medicines (45.3%) or PPIs (36.7%) on a pharmacist's advice. Older age was associated with willingness to

deprescribe PPIs on a pharmacist's advice (OR 1.05, CI 1.00–1.09; p 0.031).

Conclusion: Most patients with cancer prescribed PPIs are open to deprescribing non-cancer medicines, especially on a doctor's advice. However, willingness to deprescribe PPIs is approximately 10% lower. Key factors influencing willingness to deprescribe PPIs include older age, greater involvement in medication management, and fewer concerns about stopping. Engaging these patients in shared decision-making and educating them on the risks of prolonged PPI use and the benefits of PPI deprescribing may support safer, more effective deprescribing.

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Strengthening multidisciplinary approaches against antimicrobial resistance: A collaborative initiative reflecting on science, policy, regulatory and clinical practices

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Background: The increasing trends of antimicrobial resistance (AMR) are inferring warning signs that we cannot fail to heed. Optimizing research and practice in pharmaceutical care for infectious diseases may not be tackled by one sector or one country in isolation. The MMA Academy for Patient Centred Excellence and Innovation in Regulatory Sciences, under the auspices of the Malta Medicines Authority (MMA), endeavored to host a multidisciplinary event titled “The Silent Threat - Antimicrobial Resistance Uncovered”, bringing together clinical practitioners and researchers alongside regulators and policy makers, to discuss AMR as a mutual concern.

Purpose: Cross-country cooperation and multidisciplinary involvement are pivotal in addressing antimicrobial resistance, also considering the dwindling antibiotic development pipeline. The MMA Academy event intended to provide a platform for stakeholders to discuss how national action plans are complementing the EU One Health Approach in recognizing the interplay between human health, animal health and our ecosystem. The aim was to bridge potential gaps between scientific and practical work, policy frameworks, regulatory provisions, and clinical guidance by sharing constructive experiences, joint efforts and implementable approaches that may be relevant across healthcare systems.

Method: The collaborative initiative, funded by the *Internationalisation Partnership Awards Scheme Plus (IPAS+)* 2023 of the Malta Council for Science and Technology, was held in Malta on 30 May 2024. Keynote speakers from Norway, Ireland, Sweden and Malta were engaged and invitations for participant registration shared among local stakeholders from public and private entities. The interactive discussions covered AMR policies, antibiotic use, surveillance systems, as well as recommendations for stepping up actions to combat AMR for instance through incentives in the revision of the EU pharmaceutical legislation package. Feedback from participants was collected through a Likert scale evaluation tool.

Findings: Thirty-nine participants attended the event and all respondents to the evaluation exercise (n=22) expressed satisfaction with the content presented and willingness to attend further initiatives. Promisingly, 90% of respondents found the information relevant to their practice, anticipating performance improvement. Attendees commended the quality and depth of sessions, as well as opportunities for interdisciplinary collaboration on implementation prospects.

Conclusion: The MMA Academy, as educational institution within the national competent authority, shall continue strengthening this shared collective commitment, exchanging knowledge and best practices. Connecting science and practice, whilst fostering collaborations, enables us to prevent progress from being undone and drive us forward to continue safeguarding our patients.

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How reliable is one self-reported medication adherence item in stroke survivors? A secondary data analysis from the MAAESTRO study

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Background: Medication non-adherence has been recognized as a potentially preventable risk for stroke recurrence. Electronic monitoring (EM) is considered the gold standard to detect non-adherence. In clinical practice, easy-to-administer and cost-effective self-report questionnaires are often used. However, their reliability to detect non-adherence remains uncertain.

Purpose: To determine the reliability of a single self-reported item to assess non-adherence to direct oral anticoagulants (DOAC) in stroke survivors.

Method: We used data from the MAAESTRO study, where adherence to DOAC was assessed with EM and two self-reported items. EM data from the last four weeks of the observational phase of the MAAESTRO study were selected, and taking adherence [%] was calculated. Item 1 inquired how often patients forgot to take their DOAC with five response options (“never”, “once per month”, “once per two weeks”, “once per week”, “every day”). Item 2 inquired how many tablets patients had taken with a visual analog scale from 0% (no tablet taken) to 100% (all tablets taken). We performed group comparisons using the Kruskal Wallis test, and assessed the relationship between EM and self-reported taking adherence using Kendall's correlation coefficient (τ).

Findings: We analyzed data from 69 patients. The majority was male (55%), the median age was 78 [IQR 72–84] years, and 72% used a DOAC twice daily. Answers to both self-reported items were strongly and positively correlated ($\tau=0.77$, $z=6.89$, $p<0.05$). The median taking adherence was 92.9% [IQR 83.9–100] with EM data and 100% [IQR 98.0–100] with item 2. Patients who forgot their DOAC “once per month” showed the highest adherence (median EM 95.4% [IQR 88.4–98.2]). Patients who responded “never” (median EM 93.8% [IQR 84.2–100]) and “once per two weeks” (median EM 83.0% [IQR 75.4–86.8]) did not differ ($p=0.78$). We observed a weak positive correlation between EM and self-reported taking adherence ($\tau=0.12$, $z=1.14$, $p=0.22$).

Conclusion: Despite consistent answers to both self-reported items, high quality EM data and high quality evidence study, the association between EM and self-reported taking adherence was only weak, indicating a low reliability of self-reported items to detect non-adherence in stroke survivors. Limitations of our study include small sample size and ceiling adherence values with low scattering.

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Development and Validation of mediPORT: A Simple Pre-Operative Risk-prediction Tool for Drug-Related Problems

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Background: Drug-related problems (DRPs) in the pre-operative phase are a leading cause of adverse events and poor patient outcomes. Despite their